Reprinted
February 3, 2004

HOUSE BILL No. 1320

DIGEST OF HB 1320 (Updated February 2, 2004 7:35 pm - DI 73)

Citations Affected: IC 12-15; noncode.

Synopsis: Human services. Authorizes the office of Medicaid policy and planning (office) to implement alternative payment methodologies for payable claim payments to a hospital if the office determines that the federal Centers for Medicare and Medicaid Services will not approve the submitted payment methodology. Amends disproportionate share payment provisions for community mental health center disproportionate share providers. Removes a provision prohibiting the prescription drug advisory committee from recommending the use of funds from the prescription drug account for a state prescription drug benefit if a federal statute or program provides a similar benefit. Extends the existence of the prescription drug advisory committee until December 31, 2006. Extends the expiration of the nursing facility quality assessment from August 1, 2004, to August 1, 2006. Requires the select joint commission on Medicaid oversight to study certain effects resulting from the repeal of continuous eligibility under the Indiana Medicaid program and the children's health insurance program. Makes a technical correction.

Effective: July 1, 2003 (retroactive); July 1, 2004.

Hasler, Crawford, Frizzell, Espich

January 15, 2004, read first time and referred to Committee on Ways and Means.
January 29, 2004, amended, reported — Do Pass.
February 2, 2004, read second time, amended, ordered engrossed.

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Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

HOUSE BILL No. 1320

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-15-9, AS AMENDED BY P.L.255-2003, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2 that submits to the division during the state

fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under this section.

(c) ~~For a state fiscal year,~~ **Except as provided under section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with

respect to each county identified in STEP ONE.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of a hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

(f) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

(g) Any county's funds identified in subsection (f) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(h) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

(i) For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(j) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal

year.

SECTION 2. IC 12-15-15-9.5, AS ADDED BY P.L.255-2003, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under this section.

(c) ~~For a state fiscal year,~~ **Except as provided in section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the

division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:

(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and

(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.

The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.

(f) Except as provided in subsection (g), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(g) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(h) Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8)(D).

(i) For purposes of this section:

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 3. IC 12-15-15-9.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2004]: **Sec. 9.8. (a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:**

(1) section 9(c) of this chapter; or

(2) section 9.5(c) of this chapter;

will not be approved by the Centers for Medicare and Medicaid Services.

(b) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.

(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.

SECTION 4. IC 12-15-18-5.1, AS AMENDED BY P.L.66-2002, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 5.1. (a) For state fiscal years ending on or after June 30, 1998, the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 are authorized to make intergovernmental transfers to the Medicaid indigent care trust fund in amounts to be determined jointly by the office and the trustees, and the office and each municipal health and hospital corporation.

(b) The treasurer of state shall annually transfer from appropriations made for the division of mental health and addiction sufficient money

to provide the state's share of payments under IC 12-15-16-6(c)(2).

(c) The office shall coordinate the transfers from the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 so that the aggregate intergovernmental transfers, when combined with federal matching funds:

(1) produce payments to each hospital licensed under IC 16-21 that qualifies as a disproportionate share provider under IC 12-15-16-1(a); and

(2) both individually and in the aggregate do not exceed limits prescribed by the federal Centers for Medicare and Medicaid Services.

The trustees and a municipal health and hospital corporation are not required to make intergovernmental transfers under this section. The trustees and a municipal health and hospital corporation may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(b).

(d) A municipal disproportionate share provider (as defined in IC 12-15-16-1) shall transfer to the Medicaid indigent care trust fund an amount determined jointly by the office and the municipal disproportionate share provider. A municipal disproportionate share provider is not required to make intergovernmental transfers under this section. A municipal disproportionate share provider may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(b).

(e) A county making a payment under IC 12-29-1-7(b) or from other county sources to a community mental health center qualifying as a community mental health center disproportionate share provider **for purposes of IC 12-15-19-9.5** shall certify that the payment represents expenditures that are eligible for federal financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county in making this certification.

SECTION 5. IC 12-15-19-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 9.5. (a) For each state fiscal year ending after June 30, 2003, a community mental health center disproportionate share provider that is:**

(1) freestanding from a hospital licensed under IC 16-21; and

(2) not operated as part of a hospital licensed under IC 16-21;

shall receive a disproportionate share payment as provided in this section.

(b) Subject to subsection (f), a community mental health center disproportionate share provider described in subsection (a) shall receive a payment in the amount determined under STEP 3 of the following formula:

STEP 1: Determine the amounts certified for the community mental health center disproportionate share provider under IC 12-15-18-5.1(e).

STEP 2: Divide the amount determined under STEP 1 by a percentage equal to the state's federal medical assistance percentage for the state fiscal year.

STEP 3: Subtract the amount determined under STEP 1 from the amount determined under STEP 2.

(c) A disproportionate share payment under this section is deemed comprised of:

(1) the amounts certified for the community mental health center disproportionate share provider under IC 12-15-18-5.1(e); and

(2) the amount paid to the community mental health center disproportionate share provider under subsection (b).

(d) A disproportionate share payment under this section may not exceed the community mental health center disproportionate share provider's institution specific limit under 42 U.S.C. 1396r-4(g). The office shall determine the institution specific limit for a state fiscal year by taking into account data provided by the community mental health center disproportionate share provider that is considered reliable by the office based on:

(1) a periodic audit system;

(2) the use of trending factors; and

(3) an appropriate base year determined by the office.

(e) The office may require independent certification of data provided by a community mental health center disproportionate share provider to the office in order to determine the community mental health center disproportionate share provider's institution specific limit.

(f) Subjection to section 10(b)(2) and 10(b)(3) of this chapter, payments under this section may not result in total disproportionate share payments that are in excess of the state limit on these expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h). The office may reduce payments due under this section for a state fiscal year, on a pro rata basis, if the

reduction is necessary to avoid exceeding the state limit on disproportionate share expenditures for institutions for mental diseases.

(g) Subject to section 10(b)(3) of this chapter, total disproportionate share payments under this section for a state fiscal year must equal ten million dollars ($10,000,000). However, this amount may be reduced based upon the amounts certified for community mental health center disproportionate share providers under IC 12-15-18-5.1(e). The office may reduce the payments due under this section, on a pro rata basis, based upon the institution specific limits under 42 U.S.C. 1396r-4(g) of each community mental health center disproportionate share provider eligible for a payment under this section for that state fiscal year if the reduction is necessary to avoid exceeding the total payment limit established under this subsection.

(h) The office may recover a payment made under subsection (b) from the community mental health center disproportionate share provider if federal financial participation is disallowed for the funds certified under IC 12-15-18-5.1(e) upon which the payment was based.

SECTION 6. IC 12-15-19-10, AS AMENDED BY P.L.283-2001, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 10. (a) For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, the state shall pay providers as follows:

(1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c). The total paid to the qualified community mental health center disproportionate share providers under section 9(a) of this chapter, including the amount of expenditures certified as being eligible for federal financial participation under IC 12-15-18-5.1(e), must be at least six million dollars ($6,000,000).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(b) For state fiscal years beginning after June 30, 2000, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a). **Beginning in a state fiscal year ending after June 30, 2003, the total disproportionate share payments made to a state mental health institution described in IC 12-24-1-3 must be limited to an amount necessary to permit disproportionate share payments to be made under section 9.5 of this chapter without exceeding the state limit on disproportionate share expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h).**

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make ~~community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).~~ **disproportionate share payments under section 9.5 of this chapter.**

SECTION 7. [EFFECTIVE JULY 1, 2004] **(a) The Indiana prescription drug advisory committee is established to:**

(1) study pharmacy benefit programs and proposals, including programs and proposals in other states;

(2) make initial and ongoing recommendations to the governor for programs that address the pharmaceutical costs of low-income senior citizens; and

(3) review and approve changes to a prescription drug program that is established or implemented under a Medicaid waiver that uses money from the Indiana prescription drug

account established under IC 4-12-8-2.

(b) The committee consists of eleven (11) members appointed by the governor and four (4) legislative members. Members serving on the committee established by P.L.291-2001, SECTION 81, before its expiration on December 31, 2001, continue to serve. The term of each member expires December 31, 2006. The members of the committee appointed by the governor are as follows:

(1) A physician with a specialty in geriatrics.

(2) A pharmacist.

(3) A person with expertise in health plan administration.

(4) A representative of an area agency on aging.

(5) A consumer representative from a senior citizen advocacy organization.

(6) A person with expertise in and knowledge of the federal Medicare program.

(7) A health care economist.

(8) A person representing a pharmaceutical research and manufacturing association.

(9) A township trustee.

(10) Two (2) other members as appointed by the governor.

The four (4) legislative members shall serve as nonvoting members. The speaker of the house of representatives and the president pro tempore of the senate shall each appoint two (2) legislative members, who may not be from the same political party, to serve on the committee.

(c) The governor shall designate a member to serve as chairperson. A vacancy with respect to a member shall be filled in the same manner as the original appointment. Each member is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties. The expenses of the committee shall be paid from the Indiana prescription drug account created by IC 4-12-8-2. The office of the secretary of family and social services shall provide staff for the committee. The committee is a public agency for purposes of IC 5-14-1.5 and IC 5-14-3. The committee is a governing body for purposes of IC 5-14-1.5.

(d) Not later than September 1, 2004, the committee shall make program design recommendations to the governor and the family and social services administration concerning the following:

(1) Eligibility criteria, including the desirability of incorporating an income factor based on the federal poverty level.

(2) Benefit structure.

(3) Cost-sharing requirements, including whether the program should include a requirement for copayments or premium payments.

(4) Marketing and outreach strategies.

(5) Administrative structure and delivery systems.

(6) Evaluation.

(e) The recommendations shall address the following:

(1) Cost-effectiveness of program design.

(2) Coordination with existing pharmaceutical assistance programs.

(3) Strategies to minimize crowd-out of private insurance.

(4) Reasonable balance between maximum eligibility levels and maximum benefit levels.

(5) Feasibility of a health care subsidy program where the amount of the subsidy is based on income.

(6) Advisability of entering into contracts with health insurance companies to administer the program.

(f) This SECTION expires December 31, 2006.

SECTION 8. P.L.224-2003, SECTION 70, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: SECTION 70. (a) As used in this SECTION, "high Medicaid utilization nursing facility" means the smallest number of those nursing facilities with the greatest number of Medicaid patient days for which it is necessary to assess a lower quality assessment to satisfy the statistical test set forth in 42 CFR 433.68(e)(2)(ii).

(b) As used in this SECTION, "nursing facility" means a health facility that is:

(1) licensed under IC 16-28 as a comprehensive care facility; and

(2) certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(c) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(e) Effective August 1, 2003, the office shall collect a quality assessment from each nursing facility that has:

(1) a Medicaid utilization rate of at least twenty-five percent (25%); and

(2) at least seven hundred thousand dollars ($700,000) in annual

Medicaid revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(f) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) Twenty percent (20%) as determined by the office.

(2) Eighty percent (80%) to nursing facilities.

(g) The office may not begin collection of the quality assessment set under this SECTION before the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION.

(h) If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall cease collection of the quality assessment under the SECTION.

(i) The office shall adopt rules under IC 4-22-2 to implement this act.

(j) Not later than July 1, 2003, the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

(k) After approval of the waivers and state Medicaid plan amendment applied for under subsection (j), the office shall implement this SECTION effective July 1, 2003.

(l) The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

(m) A nursing facility may not charge the nursing facility's residents for the amount of the quality assessment that the nursing facility pays under this SECTION.

(n) This SECTION expires August 1, ~~2004.~~ **2006.**

SECTION 9. [EFFECTIVE JULY 1, 2004]: THE FOLLOWING ARE REPEALED: P.L.2002-107, SECTION 35; P.L.2002-106, SECTION 1.

SECTION 10. [EFFECTIVE JULY 1, 2004] **(a) In addition to the duties specified under IC 2-5-26, the select joint commission on Medicaid oversight established by IC 2-5-26-3 shall, to the extent the commission determines is feasible after consultation with the office of Medicaid policy and planning established by IC 12-8-6-1, study the following effects of the repeal of continuous eligibility for children under the Indiana Medicaid program and the children's health insurance program established under IC 12-17.6-2:**

(1) Effects on government, including the following:

(A) Costs to Medicaid and the division of family and children established by IC 12-13-1-1 due to more frequent recertification requirements.

(B) Loss of revenue from federal matching funds that could not be obtained because of the repeal of continuous eligibility.

(2) Effects on the economy, including the following:

(A) Indirect cost-shifting to providers due to increased charity care because recipients have lapses in eligibility.

(B) Increased burdens on township assistance (poor relief).

(3) Effects on children, including the following:

(A) Increases in the level of uninsured children in Indiana.

(B) Decreases in wellness and the effects on the educational abilities of sicker children.

(4) Effects on families, including the following:

(A) Effects on family income due to the burden of sicker children.

(B) Effects on the ability of parents to maintain stable employment due to sicker children or more burdensome recertification procedures.

(b) The select joint commission on Medicaid oversight shall submit to the legislative council before November 1, 2004, a report of its findings and recommendations concerning the study under subsection (a). The report must be submitted in an electronic format under IC 5-14-6.

(c) This SECTION expires January 1, 2005.

SECTION 11. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1320, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1320 as introduced.)

CRAWFORD, Chair

Committee Vote: yeas 26, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1320 be amended to read as follows:

Page 14, after line 42, begin a new paragraph and insert:

"SECTION 10. [EFFECTIVE JULY 1, 2004] **(a) In addition to the duties specified under IC 2-5-26, the select joint commission on Medicaid oversight established by IC 2-5-26-3 shall, to the extent the commission determines is feasible after consultation with the office of Medicaid policy and planning established by IC 12-8-6-1, study the following effects of the repeal of continuous eligibility for children under the Indiana Medicaid program and the children's health insurance program established under IC 12-17.6-2:**

(1) Effects on government, including the following:

(A) Costs to Medicaid and the division of family and children established by IC 12-13-1-1 due to more frequent recertification requirements.

(B) Loss of revenue from federal matching funds that could not be obtained because of the repeal of continuous eligibility.

(2) Effects on the economy, including the following:

(A) Indirect cost-shifting to providers due to increased charity care because recipients have lapses in eligibility.

(B) Increased burdens on township assistance (poor relief).

(3) Effects on children, including the following:

(A) Increases in the level of uninsured children in Indiana.

(B) Decreases in wellness and the effects on the educational abilities of sicker children.

(4) Effects on families, including the following:

(A) Effects on family income due to the burden of sicker children.

(B) Effects on the ability of parents to maintain stable employment due to sicker children or more burdensome recertification procedures.

(b) The select joint commission on Medicaid oversight shall submit to the legislative council before November 1, 2004, a report of its findings and recommendations concerning the study under subsection (a). The report must be submitted in an electronic format under IC 5-14-6.

(c) This SECTION expires January 1, 2005.".
Renumber all SECTIONS consecutively.

(Reference is to HB 1320 as printed January 30, 2004.)

HASLER